Date:	September 14, 1999	DSL-BQA-99-053
To:	Adult Family Homes	AFH 09
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From:	Susan Schroeder, Director Bureau of Quality Assurance	

ALERT – Danger of deaths associated with side rail use

You are encouraged to copy and distribute this information.

There has recently been an increase in unexpected deaths of persons who have side rails on their beds. During each of the last three months, June, July and August, bed side rails have been a factor in the unexpected death of a resident in a Wisconsin nursing home. This is equal to the number of nursing home residents who generally die in this manner over the course of a full year. In 1997, a resident in a Community-Based Residential Facility (CBRF) died in this manner. Side rails may be present on beds in a number of types of providers. All providers are reminded that **any device used by or near a resident or patient can present a hazard**, regardless of its purpose, or whether or not it meets the definition of a restraint.

Each provider is strongly encouraged to examine its setting for potential dangerous situations and take prompt preventative actions. There is no automatic solution. Immediate removal of devices without appropriate assessment, intervention and monitoring may also place individuals at great risk. Each provider must assess each person individually and use appropriate, individualized, protective and preventative measures for each person.

Any person, especially one who is cognitively impaired or has uncontrolled, poorly coordinated or restless movements is at high risk of getting entangled in a life threatening position with a side rail. Entrapment by a side rail can easily result in an obstructed airway or circulatory impairment and quickly lead to death. These recent accidents have resulted in asphyxiation, strangulation, chest compression or other contorted positioning with the outcome of airway obstruction, a stoppage of breathing or markedly impaired circulation.

A person may be too weak, frail or cognitively impaired to correct his or her own position as a life-saving measure. Entrapment can occur with all types of side rails, including one-quarter side rails, half side rails, three-quarter side rails, full side rails, or other similar devices. These devices may not meet the definition of a restraint for the individual, especially when he or she is awake and somewhat alert; however, **they may still be a hazard.** Those that are not properly fitted or not properly designed for the bed or the mattress pose an even greater hazard.

In 1995 the federal Food and Drug Administration (FDA) published a safety alert regarding the dangers of side rail entrapment. A copy of that alert is attached and it can be obtained from the Internet at

http://www.fda.gov/cdrh/bedrails.html

The Code of Federal Regulations for Nursing Homes at 42 CFR 483.25(h) requires that **"The facility must ensure that—(1)The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents."** (F323/F324)

The Code of Federal Regulations for Intermediate Care Facilities for the Mentally Retarded (ICF-MRs) at 42 CFR 483.450(b)(2) requires that **"Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected."** (W285)

The Federal Conditions of Participation for Hospices at 42 CFR 418.56(c) require that **"The hospice retains professional management responsibility for those services and ensures that they are furnished in a safe and effective manner by persons meeting the qualifications of this part, and in accordance with the patient's plan of care and the other requirements of this part."** (L124)

The Federal Conditions of Participation for Hospitals at 42 CFR 482.13(e)(4) require that **"The condition of the restrained patient must be continually assessed, monitored, and reevaluated."**

The Wisconsin Administrative Code for Community-Based Residential Facilities (CBRFs) at HFS 83.21(4)(w) requires that **"…The CBRF shall safeguard residents who cannot fully guard themselves from an environmental hazard to which it is likely that they will be exposed, including both conditions which would be hazardous to anyone, and conditions which are hazardous to the resident because of the resident's condition or handicap."**

The Wisconsin Administrative Code for Adult Family Homes at HFS 88.10(3)(L) requires that **"A resident shall have all the following rights…To a safe environment in which to live. The adult family home shall safeguard residents who cannot fully guard themselves from environmental hazards to which they are likely to be exposed, including conditions which would be hazardous to anyone and conditions which would be or are hazardous to a particular resident because of the resident's condition."**

Manufacturers and sales representatives do not make the final determination of whether or not a device is a restraint. The provider is responsible for the assessment of *the resident/patient/client* and for making the determination on an individual basis of what is or is not a restraint. The provider is responsible for assessing the safety of a person and the potential hazards for *any* device used on or near a resident/patient/client regardless of whether or not it meets the definition of a restraint. If side rails or other similar devices are used, protective measures, such as proactively checking the person, need to be put into place to protect the person from the negative outcomes associated with that hazard.

Many residents/patients/clients may be safer *without* a side rail than *with* a side rail. Using lower beds, floor cushioning such as exercise mats, frequent supervision or other appropriate measures can often ensure better safety than the use of a side rail because the side rail can be a life-threatening hazard.

Previous Bureau of Quality Assurance (BQA) training and memos, as well as professional health care literature, have presented multiple techniques and suggestions for how to facilitate safety without increasing the risk of accidental death. Attached to this memo is a recommended reading list that can be used for training staff on alternatives to restraints. These and other timely resources can be obtained from the sources listed or from your local hospital or medical library.

The federal Health Care Financing Administration (HCFA) has a web site that provides a newsletter with up-to-date information on restraint reduction at: **http://www.hcfa.gov/pubforms/rrnews.htm**.

Resources from the Wisconsin Association of Medical Directors (WAMD) are available through the American Medical Directors Association (AMDA) on the national web site, including a recent newsletter

article entitled "Today's Problems are a Result of Yesterday's Solutions": **http://www.amda.com** Select State Chapters from the menu, then click on Wisconsin.

Questions about the information in this memo may be directed to the following contact persons:

Questions regarding hospitals and hospices should be directed to Beth Stellberg, Chief, Health Services Section at (608) 266-3878.

Questions for nursing homes, facilities for the developmentally disabled, community-based residential facilities and adult family homes should be directed to the appropriate regional office:

Southern Regional Office 3514 Memorial Drive Madison, WI 53704-1162 FAX: (608) 243-2389	Phyllis Tschumper, RFOD	(608) 243-2374
Southeastern Regional Office 819 N. 6th St. Rm. 875 Milwaukee, WI 53202-1606 FAX: (414) 227-4139	Tony Oberbrunner, RFOD	(414) 227-4908
Northeastern Regional Office 200 N. Jefferson St. Suite 211 Green Bay, WI 54301-5182 FAX: (920) 448-5254	Pat Benesh, RFOD	(920) 448-5249
Northern Regional Office 1853 N. Stevens Street P.O. Box 1246 Rhinelander, WI 54501-1246	Marianne Missfeldt, RFOD	(715) 365-2802
Western Regional Office 610 Gibson St. Eau Claire, WI 54701-3667 FAX: (715) 365-2815	Joe Bronner, RFOD	(715) 836-4753

Attachments

RISKS & DANGERS OF SIDE RAILS

Feinsod, Fred, Moore, M., Levenson, S., "Eliminating Full-length Bed Side Rails from Long-Term Care Facilities," Nursing Home Medicine, The Annals of Long-Term Care, 1997.

Miles, Steven and Irvine, Patrick, "Deaths Caused by Physical Restraints," The Gerontologist, Vol. 32, No. 6, 1992.

Miles, Steven, "Restraints and Sudden Death," Letter to the Editor, Journal of the American Geriatrics Society, 41 (9), 1993.

Miles, Steven, "A Case of Death by Physical Restraint: New Lessons from a Photograph," Journal of the American Geriatrics Society, 44: 291-292, 1996.

Miles, Steven and Parker, Kara, "Pictures of Fatal Bedrail Entrapment," Letters to the Editor, American Family Physician, Vol. 58, No. 8, November 15, 1998.

Parker, Kara and Miles, Steven, "Deaths Caused by Bedrails," Journal of the American Geriatrics Society, Vol. 45, No. 7, July 1997.

INFORMATION ON PREVENTING FALLS

Capezuti, E., Evans, L., Staumpf, N., and Maislin, G., "Physical Restraint Use and Falls in Nursing Home Residents," Journal of the American Geriatrics Society, June, 1996.

Capezuti, E., Evans, L., Staumpf, N., Maislin, G., and Grisso, J., "Relationship Between Physical Restraint and Falls and Injuries Among Nursing Home Residents," Journal of Gerontology, Medical Sciences, 1998, Vol. 53A, No. 1, M47-M52

Daltroy, L., Phillips, C., Eaton, H., Larson, M., Partridge, A., Logigian, A., and Liang, M., "Objectively Measuring Physical Ability in Elderly Persons: The Physical Capacity Evaluation," American Journal of Public Health, April, 1995.

Lipsitz, Lewis, "An 85-Year Old Woman with a History of Falls, Clinical Crossroads, Journal of the American Medical Association, July 3, 1996.

Meddaugh, Dorothy, Friendenberg, D., Knisley, R., "Special Socks for Special People: Falls in Special Care Units," Geriatric Nursing, January/February 1996.

Morse, Janice M., Preventing Patient Falls (book) SAGE Publications, ISBN: 0-7619-0593-6.

Pasqua, Sandy, "Fall Programs That Work," Contemporary Long Term Care, April 1996.

Province, M., et. al., "The Effects of Exercise on Falls in Elderly Patients," Journal of the American Medical Association, May 3, 1995.

Ray, Wayne A., et. al., "A Randomized Trial of a Consultation Service to Reduce Falls in Nursing Homes," Journal of the American Medical Association, August 20, 1997.

Thapa, P., P. Gordon, R. Fought, W. Ray, "Psychotropic Drugs and Risk of Recurrent Falls in Ambulatory Nursing Home Residents," American Journal of Epidemiology, Vol. 142, No. 2, 1995.

Tideiksaar, Rhein, "Preventing Falls: How to Identify Risk Facts, Reduce Complications," Geriatrics, February, 1996.

Tinetti, Mary E., W. L. Liu, E. Claus, "Predictors and Prognosis of Inability to Get Up After Falls Among Elderly Persons," Journal of the American Medical Association, January 6, 1993.

Tinetti, Mary E., "Prevention of Falls and Fall Injuries in Elderly Persons: A Research Agenda," Preventative Medicine, 23, 756-762, 1994.

Tinetti, Mary E., S. Inouye, T. Gill, J. Doucette, "Shared Risk Factors for Falls, Incontinence, and Functional Dependence," Journal of the American Medical Association, May 3, 1995.

INFORMATION FOR FAMILIES

"Avoiding Physical Restraints. What All Nursing Home Residents and Families Need to Know," Pamphlet PSL-3113, Wisconsin Department of Health and Family Services, Division of Supportive Living, Bureau of Quality Assurance, May 1998.

Copies may be obtained by calling any regional office of the Bureau of Quality Assurance or by writing to:

Bureau of Quality Assurance
P.O. Box 2969
Madison, WI 53701-2969

"Avoiding Physical Restraint Use: New Standards in Care, A guide for residents, families and friends," booklet produced by the National Citizens Coalition for Nursing Home Reform (NCCNHR), copyright 1993.

Copies may be obtained by contacting them at:

National Citizens Coalition for Nursing Home Reform
1224 16th Street N.W., Suite 202
Washington, D.C. 20036-2211
(202) 332-2275

"Avoiding Drugs Used as Chemical Restraints: New Standards in Care," a booklet addressing avoiding unnecessary drugs is available from the same organization, NCCNHR.

"A Family Guide to Restraint-Free Care," video for families from the video series, "Everyone Wins! Quality Care Without Restraints."

Available from:

The Independent Production Fund
45 West 45th Street
New York, NY 10036
1-800-727-2470

"Safety Without Restraints," illustrated booklet published by the Minnesota Department of Health. For additional copies, call (651) 215-8700 or visit their Website at:

www.health.state.mn.us/divs/fpc/safety.htm

INFORMATION FOR HOSPITAL STAFF

Many resources geared toward physicians and nursing home staff are also helpful for hospital staff, especially regarding falls and restraint deaths from side rails. The articles listed below are of particular interest to hospital staff members.

"Strategies to Reduce Use of Restraints, Special Report - Restraint and Seclusion Standards," Joint Commission Perspectives, November-December 1997, pages 18-24.

Bryant, H. and Fernald, L., "Nursing Knowledge and Use of Restraint Alternatives: Acute and Chronic Care," Geriatric Nursing 18, 1997.

Clifford, Timothy, M.D., Medical Director, Maine Medicaid Program, "Why Are Hospitals Dangerous for Nursing Home Residents?," published in "Case Mix Update, A Newsletter of the Maine Case Mix Payment and Quality Assurance Project, May 1997.

Greenberg, R., "OBRA's Challenge to Physical Therapy: Find Alternatives to Physical Restraints," PT Bulletin, April 26, 1996, p. 11.

Janelli, L.M., "Physical Restraint Use in Acute Care Settings," Journal of Nursing Care Quality. April 1195 9(3) p.86-92.

Mion, L. C., Minnick A. and Palmer, R., "Physical Restraint Use in the Hospital Setting: Unresolved Issues and Directions for Research," The Milbank Quarterly, 74 (3), 1996.

Robinson, B.E., "Death by Destruction of Will: Lest We Forget," Archives of Internal Medicine, Nov. 13, 1995.

Strumpf, Neville E., RN, FAAN, and Doris Schwartz, "Achieving Restraint-Free Care in Hospital Settings," Gerontological Nursing School of Nursing, University of Pennsylvania, published in "Untie the Elderly," Newsletter, December, 1997.

Winslow, Elizabeth H., RN, FAAN, Presbyterian Hospital, Dallas, Texas, "Do Restraints Really Protect Intubated Patients?," American Journal of Nursing, June, 1996.

RESOURCE ORGANIZATION:

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
One Renaissance Boulevard
Oakbrook Terrace, IL 60181

INFORMATION FOR PHYSICIANS

Multiple resources listed here are appropriate for hospital and nursing home staff, as well as physicians. The sections on falls and side rails are also of particular interest to physicians and professional staff.

Castle, Nicholas, and Fogel, Barry, "Characteristics of Nursing Homes That Are Restraint Free," The Gerontologist, Vol. 38, No. 2, 1998.

Dunbar, Joan R., Neufeld, H. White and L. Libow, "Retrain, Don't Restrain: The Educational Intervention of the National Nursing Home Restraint Removal Project," The Gerontologist, Vol. 36, No. 4, 1996.

Frengley, J.D. "The Use of Physical Restraints and the Absence of Kindness," Journal of the American Geriatrics Society, 44:1125-1127, 1996.

Frank, Christopher, Hodgetts, Geoffrey and Puxty, John, "Safety and Efficacy of Physical Restraints for the Elderly, Review of the Evidence," Canadian Family Physician, December, 1996.

Kapp, Marshall, "Nursing Home Restraints and Legal Liability," The Journal of Legal Medicine, 1992.

Morley, John E., "Update on Nursing Home Care," Annals of Long-Term Care, Vol. 7, No. 1, January 1999.

Schieb, David, Protas, Elizabeth, Hasson, Scott M., "Special Feature: Implications of Physical Restraint and Restraint Reduction of Older Persons," Topics in Geriatric Rehabilitation, December, 1996.

INFORMATION FOR NURSING HOME STAFF

Cohen, Camille, R. Neufeld, J. Dunbar, L. Pflug, B. Breuer, "Old Problems, Different Approach: Alternatives to Physical Restraints," Journal of Gerontological Nursing, February, 1996.

Colorado Foundation for Medical Care, "Assessment and Alternatives Help Guide, Restraint Reduction, Falls, Behavior Problems, Wandering," Phone #303-695-3300, Ext. 3005.

Dunbar, Joan, et. al., "Taking Charge, The Role of Nursing Administrators in Removing Restraints," Journal of Nursing Administration, Vol. 27, No. 3, March 1997.

Ejay, F. K., Rose, M. S. and Jones, J. A., "Changes in Attitudes Toward Restraints Among Nursing Home Staff and Residents' Families Following Restraint Reduction," The Journal of Applied Gerontology 15 (4), 1996.

Evans, Lois and Strumpf, Neville, "Myths About Elder Restraint," IMAGE: Journal of Nursing Scholarship, Vol. 22, No. 2, 1990.

Fleming, Kevin, "Changing Physician Behavior," Topics in Geriatric Medicine and Medical Direction, Vol. 13, Issue 4, December, 1998.

McHutchion, E., and Morse, J., "Releasing Restraints, A Nursing Dilemma," Journal of Gerontological Nursing, Vol. 15, No. 2, 1989.

Neufeld, R. R. and Dunbar, J. M., "Restraint Reduction: Where Are We Now?," Nursing Home Economics 4 (3), 1997.

Newbern, Virginia and Lindsey, Ina, "Attitudes of Wives Toward Having Their Elderly Husbands Restrained," Geriatric Nursing, Vol. 15, No. 3, May/June 1994.

Rader, Joanne, "A Comprehensive Staff Approach to Problem Wandering," The Gerontologist, Vol. 27, No. 6, 1987.

Rader, Joanne, J. Doan and Sr. M. Schwab, "How to Decrease Wandering, a Form of Agenda Behavior," Geriatric Nursing, July/August, 1985.

Strumpf, Neville and Evans, Lois, "The Ethical Problems of Prolonged Physical Restraint," Journal of Gerontological Nursing, Vol. 17, No. 2, 1991.

Werner, P., Koroknay, Braun and Cohen-Mansfield, "Individualized Care Alternatives Used in the Process of Removing Physical Restraints in the Nursing Home," Journal of the American Geriatrics Society, 42 (3), 1994.